June 15, 2000

Michael H. Trujillo, M.D., M.P.H., M.S.
Assistant Surgeon General
Director, Indian Health Service

Dear Dr. Trujillo,

The Level of Need Funded (LNF) Workgroup met June 14-15 to consider tribal comment on the resource distribution formula earlier proposed by the workgroup. The purpose of this letter is to inform you of recommendations to revise the FY 2000 formula and to continue development and consultation efforts to finalize a methodology for future years.

GENERAL RECOMMENDATIONS

1. The workgroup reaffirmed support for LNF study as the most rigorous and scientific analysis that is currently available to measure the health resources disparity between Indian people and the general US population. Although imperfect, the study provides a credible way to identify health care funding needs for Indian people in comparison to mainstream health benefits plans. The IHS should continue working with tribes and Indian health leaders to adapt this actuarial approach and refine the data used in the LNF study to the local level.

2. The workgroup recommends that IHS distinguish resource distribution formula from the LNF study itself. As stated in one letter, "It is unfortunate that there is this strong opposition to the LNF Part II report since most, if not all tribal leaders, support the LNF Part I approach of using actuarial data to better measure true Indian health needs and to determine national funding of Indian people." The comments on the Part II report suggest that tribes hold varying views in support or opposition to the resource distribution formula, but not to the actuarial study itself. The resource distribution formula proposed in Part II is designed to comply with Section 102 – Indian Health Care Improvement Fund, P.L. 94-437 as amended. Therefore, the workgroup recommends the resource distribution formula be henceforth labeled the Indian Health Care Improvement Fund (IHCIF) formula.

3. The workgroup recommends that IHS use the IHCIF formula, as revised below, to allocate the FY 2000 Indian Health Care Improvement Funds as an *interim* decision while continuing consultation with tribes to finalize a formula for annual distribution of IHCIF funds.

4. The workgroup does not recommend use of the CHEF or TSA formulas, which also have been proposed as alternatives. The workgroup believes that CHEF and TSA formulas, while appropriate for other purposes, do not comply with the specific requirements in the P.L. 93-437, Section 102 (b)(2)(A) that specifies "health status and resource deficiency" as the distribution criteria. The Act further defines health status and resource deficiency as unachieved health status objectives and resources

needs taking into account "the actual cost of providing health care services given local geographic, climatic, rural, and other circumstances." The distribution formula proposed by the workgroup does include these factors whereas the CHEF and TSA formulas do not.

5. The IHCIF formula is to be recalculated each year. The workgroup reaffirms the *iterative* nature of this process, which is to be applied annually, continually refined, and updated with the most recent data available. This means that health status and resource deficiencies, as measured now, are not immutably fixed and can change in future iterations as we achieve greater equity in resource availability and health status. The workgroup believes that the IHCIF formula will create incentives that will improve local data quality in future years.

REVISIONS TO THE IHCIF DISTRIBUTION FORMULA

The proposed IHCIF formula contains three factors that adapt the LNF actuarial results for a resource distribution formula. The following recommendations revise these factors consistent with tribal feedback.

1. The workgroup recommends using FY 1998 user counts to update results for the FY 2000 IHCIF distribution formula, including pending user count adjustments expected during June. (The workgroup recommends additional work to reconsider definitions and procedures for determining counts used in the IHCIF formula – see below).

2. Price Factor for Purchased Services: For the FY 2000 IHCIF distribution, the workgroup recommends retaining the health care price index for local geographic areas as originally proposed. Workgroup members viewed the assertion that "values of the health care price index for rural areas were unrealistically low" as plausible. Unfortunately, systematic data justifying a higher price index was not offered or available. Moreover, an unsubstantiated "floor" price index would break with the underlying actuarial basis of the LNF study and reduce credibility. Before altering the health care price index in future iterations of the IHCIF formula, the workgroup recommends further study to systematically measure actual purchase prices at the operating unit level taking into account referral patterns, case complexity, geographic isolation, and other circumstances.

3. Size Factor for Direct Services: The workgroup recommends retaining the "size" factor as originally formulated. The size factor is a sliding scale that adjusts for higher unit costs experienced in smaller operating units and greater cost efficiency in larger operating units. A substantial majority of operating units in Indian country are smaller than the US average. A sliding scale adjustment for size is an important part of the distribution formula.

4. Health Status Factor: The workgroup recommends increasing the importance of the health status factor in the distribution formula by increasing its weight of the current health status index from 50% to 100%. This action is in response to a number of tribal comments that health status was insufficiently valued in the original formula.

5. The workgroup considered other Indian health disparity data that further highlighted regional differences. The workgroup recommends the IHS obtain a professional contractor to develop a more appropriate health status index for use in the IHCIF formula. Some options reviewed by the workgroup are as follows:

   a) Disparities related to high birth rates, and excess low and high birth weight infants among Indians,
   b) Disparities related to low life expectancy of Indians,
   c) Disparities related to leading causes of death (injuries, cancer, diabetes, heart disease, alcoholism),
   d) Disparities related to poor health conditions due to poverty.

6. Consistent with guidelines in the Indian Health Care Improvement Act for "meeting the health needs of Indians in an efficient and equitable manner", the workgroup recommends a major policy objective for the agency to raise operating units with the greatest deficiency (lowest LNF %) up to the IHS average. If the Congress annually funds the IHCIF (e.g., $50-100 million), the IHS average LNF % will rise and IHCIF funds will gradually benefit ever-expanding numbers of operating units as all rise toward funding parity with the general US population.

RECOMMENDATIONS FOR CONTINUED CONSULTATION

The workgroup had several contrasting viewpoints.

1. Some workgroup members believe that substantial consultation about the IHICF formula has already occurred. These include numerous mailings, meetings, and workshops. These members believe that a high profile national meeting solely for IHCIF might not serve a useful purpose, that such a meeting could backfire and introduce further divisions within Indian country (as happened to BIA with the reorganization package). These members believe that Area or regional meetings may be more effective framework for continuing consultation.

2. Other workgroup members suggested that only a national meeting with tribal leaders would be sufficient to conclude consultation. However, they suggest combining the IHCIF distribution issue with other important consultation issues. Also, consider framing additional consultation in terms of FY 2001 funding cycle given the immediacy of the FY 2000 decision.

3. Managers within the IHS system, especially at Areas and Service Units, appear relatively uninformed and need training so they can understand and articulate the issue with local tribes and communities.

4. The workgroup believes that the door for consultation should never be closed. The IHS should continually engage tribal leaders to annually refine and improve resource distribution formula and data. Although an extensive period of information sharing, mailings, meetings, and discussions, have and will continue to contribute to consultation on the IHCIF formula, consultation is never complete. Nevertheless, the Director must soon make a decision on the FY 2000 IHCIF distribution. Like all decisions about which there are differing views, this decision

should be made in light of the best information and advice available at the time, recognizing the possibility of new data and other improvements in future years.

RECOMMENDATIONS RELATED TO BUDGET FORMULATION

1. Discuss approaches to integrating the actuarial approach into IHS resource planning, formulation, and management systems especially targeting this credible tool to help build the resource base for Indian health. The IHS should release the Part I LNF report to the Congress and seek high-level discussions with the OMB to plan how to use LNF study findings in formulating and justifying IHS budget increases.

2. The workgroup notes that the Phase I LNF report, which identifies funding need for the personal health care services, was generally accepted without controversy. Therefore, the workgroup recommends incorporating the LNF funding results for personal health care services in the next budget formulation cycle.

3. The public health aspects of the Indian health system are not addressed in the LNF study. It should be understood that LNF actuarial findings relate only to personal health care services. IHS should sponsor additional work to define needs for public health functions including infrastructure, sanitation, traditional health practices, and other non-medical aspects of the Indian health system. The goal should be to obtain, to the extent possible, a comparable degree of scientific and economic credibility as provided by the actuarial approach for personal health services.

OTHER RECOMMENDATIONS

1. The workgroup recommends that IHS assign staff to pursue a project with HCFA to match IHS patient information with HCFA payment data. This research is critical to refining estimates of other health resources available to Indian people.

2. The workgroup recommends that IHS study the possibility of improving definitions, data, and the process for more appropriate and timely counts of Indian users for resource distribution formula.

3. The workgroup reaffirmed a position that newly recognized tribes should not be funded from resources existing tribes would otherwise receive.

This concludes our recommendations. We trust these new recommendations will be helpful in moving towards eliminating the deficiencies in Indian health status and resources. On behalf of the members of the workgroup, the co-chairs express our sincere appreciation for your support for the LNF workgroup and its research.

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Cliff Wiggins
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